

EXIBIT B



VIA FILE UPLOAD

May 10, 2022

Brad Lander
Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
Form Version: NYC-COMPT-BLA-LE-C4

Re: Notice of Claim Class Action - RULE 50

Dear Mr. Lander:

We represent the below list of New York City (the "City") employees who have been placed on "indeterminate involuntary leave without pay" for exercising their right to refuse to Covid-19 vaccine based on their First Amendment Right to refuse and based on the City's lack of authority to create the Covid-19 vaccine requirement because the authority is pre-empted by OSHA's authority to set workplace safety standards.

Therefore, this letter and the attached documents will serve as the Notice of Claims for Employment and Personal Injury Damages for City's Violations of the employees First Amendment Rights, various New York Civil Service Disciplinary Laws, Title VII Religious Harassment, the American's With Disability Act, and the New York City Human Rights Act, which provides punitive damages for the City's reckless disregard for the rights of its employees.

Attached find the following:

1. one (1) completed Employment and Personal Injury Claim form for all employees, and we have provided an Excel spreadsheet that contains all of the data required to be provided in the attached forms.
2. Spreadsheet list of employee information in support of the claim forms
3. Exhibit A – Memorandum of Legal Causes of Action - pages 1-94

List of Employees for which the Notice of Claim applies and is provided for "All similarly situated employees":

1. Curtis Boyce
2. Sara Coombs-Moreno
3. Elizabeth Loiacono
4. Jesus Coombs
5. Julia Harding
6. Angela Velez
7. Sancha Browne
8. Amoura Bryan
9. Ayse Ustares



10. Zena Wouadjou
11. Remo Dello Ioio
12. Charisse Ridulfo
13. Sancha Browne
14. Tracy-Ann Francis-Martin
15. Kareem Campbell
16. Michelle Hemmings Harrington
17. Mark Mayne
18. Carla Grant
19. Cassandra Chandler
20. Aura Moody
21. Suzanne Deegan
22. Evelyn Zapata
23. Christine O'Reilly
24. Edward Weber
25. Maritza Romero
26. Sean Milan
27. Sonia Hernandez
28. Jeffrey B. Hunter
29. Rasheen Odom
30. Maria Figaro
31. Sara Coombs-Moreno
32. Frankie Trotman
33. Yulonda Smith
34. Roseanna Mustacchia
35. Jessica Csepku
36. Natalya Hogan
37. Bruce Reid
38. Joseph Rullo
39. Cheryl Thompson
40. Dianne Baker-Pacius

If you have any questions or need additional information, please feel free to contact me on my cell number at 602-326-8663.

Sincerely,

Jo Saint-George, Esq.
Jo Saint-George, Esq.
Chief Legal Officer

New York City Comptroller
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1 Centre Street
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City Employment Claim Form

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I am filing: ☐ On behalf of myself.☒ Attorney is filing.☐ On behalf of someone else. If on someone else's behalf, please provide the following information:

Last Name:

First Name:

Relationship to
the claimant:**Claimant Information**

*Last Name:

USTARES

*First Name:

AYSE

*Address:

Address 2:

*City:

*State:

*Zip Code:

*Country:

Date of Birth:

Soc. Sec #:

*Phone:

*Email Address:

*Retype Email:

Occupation:

Current City
Employee?☒ Yes ☐ No ☐ NA

Current Agency: DEPT. OF EDUCATION

Gender:

☐ Male ☒ Female ☐ Other**Attorney Information (if represented by attorney)**

+Firm or Last Name:

WOMEN OF COLOR 4 EQUAL JUSTICE

+Firm or First Name:

JO SAINT-GEORGE, ESQ.

+Address:

MAILING - 350 E. DIAMOND AVE.

Address 2:

UNIT 4077

+City:

GIATHERSBURG

+State:

MARYLAND

+Zip Code:

20877

Tax Id:

261289930

Phone:

(602) 326-8663

Email Address:

JO@WOC4EQUALJUSTICE.ORG

Retype Email:

JO@WOC4EQUALJUSTICE.ORG

Name and place where the claim arose

Event Date from:

09/09/2021

Format: MM/DD/YYYY

Event Date to:

05/11/2022

Format: MM/DD/YYYY

Event Location:

ONGOING RELIGIOUS & DISABILITY
HARASSMENT & DISTRESS

Address:

PS 19 JUDITH K. WEISS

Address 2:

BRONX

State:

NEW YORK

Borough:

BRONX

* Denotes required fields. Either a claimant or attorney email address is required.

+ Denotes field that is required if Attorney is filing.



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***Nature of Claim/Description of Claim**

THE WOMEN OF COLOR FOR EQUAL JUSTICE ARE REPRESENTING MULTIPLE CITY WORKERS AND IS SEEKING CLASS CERTIFICATION OF WHICH THIS EMPLOYEE HAS BEEN NAME AS PART OF THE PROPOSED CLASS. A LAWSUIT HAS BEEN FILED TO PRESERVE STATUTES OF LIMITATIONS. SEE DETAILS OF BELOW CLAIMS IN EXHIBIT A IN THE BELOW LINK - [HTTP://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM%20WITH-EXHIBITS-FINAL-V2.PDF](http://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM%20WITH-EXHIBITS-FINAL-V2.PDF) - CLAIMS:

#1. OSHA PRE-EMPTION OF NEW YORK CITY DEPARTMENT OF HEALTH ORDERS - THE CITY THROUGH THE DEPARTMENT OF HEALTH LACKED AUTHORITY TO ISSUE THE COVID-19 VACCINE ORDERS FROM AUGUST 2021 TO DECEMBER 2021 THAT ONLY APPLIED TO CITY EMPLOYEES. ONLY OSHA HAS AUTHORITY TO CREATE AND IMPLEMENT WORKPLACE SAFETY STANDARDS. THE ORDERS WERE NOT FOR THE GENERAL GOO, CITY FAILED TO TRAIN EMPLOYEES REGARDING ALL OSHA RISK MITIGATION CONTROLS FOR WORKPLACE SAFETY AGAINST COVID-19 - SPECIFICALLY THE RIGHT TO "REMOTE WORK" AND SAFETY EQUIPMENT - SPECIFICALLY RESPIRATORS AND POWERED AIR PURIFYING RESPIRATORS (PAPR) -

#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

#3 THE CITY ENGAGED IN DISCRIMINATORY HARASSMENT AND COERCION IN VIOLATION OF: TITLE VII, THE ADA (THE EMPLOYEES IN THE PROTECTED CLASS OF THOSE WITH A "PERCEIVED DISABILITY" DUE TO THEIR "UNVACCINATED STATUS" OR "VACCINE DEFICIENCY") AND IN VIOLATION OF THE NEW YORK CITY HUMAN RIGHTS ACT FOR THE SAME REASONS ABOVE. #4 WRONGFUL DISCIPLINE - THE CITY WRONGLY PLACED EMPLOYEES ON INVOLUNTARY INDETERMANAT LEAVE WITHOUT PAY BUT CLAIMED TO TERMINATE THEM IN VIOLATION OF CIVIL SERVICE LAWS A. EDUCATION LAW §3020 FOR ALL TENURED TEACHERS IN THE DEPARTMENT OF EDUCATION;

If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

*Agency: DEPT. OF EDUCATION
Address: 65 COURT ST.
Address 2: #102
City: BROOKLYN
State: NEW YORK
Zip Code: 11201

Work days lost: 180



Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

+ + Contractor Name:

**Denotes required field*

+ + Denotes field that is required if you were employed by a City Contractor.



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Salary/Benefit Claimed Damages

Date From: Date To: Amount:

Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
Total:			0.00

Additional Claimed Damages

Amount:

Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY	
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREEDOM	
Specify:	PUNITIVES CALCULATED BASED ON [REDACTED] SALARY	
Specify:	ATTORNEY FEES	
Specify:		
Total:		

****Total
Claimed
Amount:**

--	--

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

*Denotes field that is required.

**Total Claimed Amount will be automatically calculated after all required fields are entered.

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Last Name:

First Name:

Relationship to
the claimant:**Claimant Information**

*Last Name:

MOODY

*First Name:

AURA

*Address:

Address 2:

*City:

*State:

*Zip Code:

*Country:

Date of Birth:

Soc. Sec #:

*Phone:

*Email Address:

*Retype Email:

Occupation:

Current City
Employee?

Yes



No



NA

Current Agency: DEPT. OF EDUCATION

Gender:



Male



Female



Other

☒ Attorney is filing.**Attorney Information (if represented by attorney)**

+Firm or Last Name:

WOMEN OF COLOR 4 EQUAL JUSTICE

+Firm or First Name:

JO SAINT-GEORGE, ESQ.

+Address:

MAILING - 350 E. DIAMOND AVE.

Address 2:

UNIT 4077

+City:

GIATHERSBURG

+State:

MARYLAND

+Zip Code:

20877

Tax Id:

261289930

+Phone:

(602) 326-8663

+Email Address:

JO@WOC4EQUALJUSTICE.ORG

+Retype Email:

JO@WOC4EQUALJUSTICE.ORG

The time and place where the claim arose

*Incident Date from:

09/09/2021

Format: MM/DD/YYYY

*Incident Date to:

05/11/2022

Format: MM/DD/YYYY

*Incident Location:

ONGOING RELIGIOUS & DISABILITY
HARASSMENT & DISTRESS

Address:

65 COURT STREET

Address 2:

City:

BROOKLYN

State:

NEW YORK

Borough:

BROOKLYN (KINGS)

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If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

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Address: 65 COURT ST.
Address 2: #102
City: BROOKLYN
State: NEW YORK
Zip Code: 11201

Work days lost: 210

Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

+ + Contractor Name:

**Denotes required field*

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Salary/Benefit Claimed Damages

Date From: Date To: Amount:

Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
Total:			0.00

Additional Claimed Damages

Amount:

Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY	
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREEDOM	
Specify:	PUNITIVES CALCULATED BASED [REDACTED]	
Specify:	ATTORNEY FEES	
Specify:		
Total:		

****Total
Claimed
Amount:**

[REDACTED]	
------------	--

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First Name:

Relationship to
the claimant:**Claimant Information**

*Last Name:

BOYCE

*First Name:

CURTIS

*Address:

Address 2:

*City:

*State:

*Zip Code:

*Country:

Date of Birth:

Soc. Sec #:

*Phone:

*Email Address:

*Retype Email:

Occupation:

Current City
Employee?

Yes



No



NA

Current Agency: DEPT. OF EDUCATION

Gender:



Male



Female



Other

☒ Attorney is filing.**Attorney Information (if represented by attorney)**

+Firm or Last Name:

WOMEN OF COLOR 4 EQUAL JUSTICE

+Firm or First Name:

JO SAINT-GEORGE, ESQ.

+Address:

MAILING - 350 E. DIAMOND AVE.

Address 2:

UNIT 4077

+City:

GIATHERSBURG

+State:

MARYLAND

+Zip Code:

20877

Tax Id:

261289930

+Phone:

(602) 326-8663

+Email Address:

JO@WOC4EQUALJUSTICE.ORG

+Retype Email:

JO@WOC4EQUALJUSTICE.ORG

The time and place where the claim arose

*Incident Date from:

09/09/2021

Format: MM/DD/YYYY

*Incident Date to:

05/11/2022

Format: MM/DD/YYYY

*Incident Location:

ONGOING RELIGIOUS & DISABILITY
HARASSMENT & DISTRESS

Address:

11625 GUY R. BREWER RD

Address 2:

City:

JAMAICA

State:

NEW YORK

Borough:

QUEENS

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State: NEW YORK
Zip Code: 11201

Work days lost: 210
Amount Earned Weekly: [REDACTED]
Amount Earned Yearly: [REDACTED]

Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

+ +Contractor Name: [REDACTED]

**Denotes required field*

+ +Denotes field that is required if you were employed by a City Contractor.



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Date From: Date To: Amount:

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Annual Leave/Vacation:			
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Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY
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Specify:	ATTORNEY FEES
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I am filing: ☐ On behalf of myself.

☐ On behalf of someone else. If on someone else's behalf, please provide the following information:

Last Name:

First Name:

Relationship to
the claimant:

Claimant Information

*Last Name:

BRYAN

*First Name:

AMOURA

*Address:

Address 2:

*City:

*State:

*Zip Code:

*Country:

Date of Birth:

Soc. Sec #:

*Phone:

*Email Address:

*Retype Email:

Occupation:

TEACHER REMOTE HOME

Current City
Employee?

☒ Yes ☐ No ☐ NA

Current Agency:

DEPT. OF EDUCATION

Gender:

☐ Male ☒ Female ☐ Other

☒ Attorney is filing.

Attorney Information (if represented by attorney)

+Firm or Last Name:

WOMEN OF COLOR 4 EQUAL JUSTICE

+Firm or First Name:

JO SAINT-GEORGE, ESQ.

+Address:

MAILING - 350 E. DIAMOND AVE.

Address 2:

UNIT 4077

+City:

GIATHERSBURG

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MARYLAND

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20877

Tax Id:

261289930

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+Email Address:

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HARASSMENT & DISTRESS

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BROOKLYN

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BROOKLYN (KINGS)

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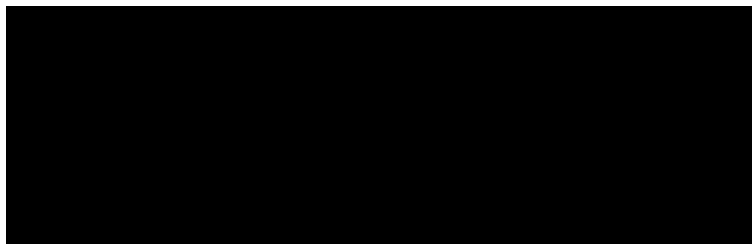
#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

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If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

*Agency:	DEPT. OF EDUCATION
Address:	65 COURT ST.
Address 2:	#102
City:	BROOKLYN
State:	NEW YORK
Zip Code:	11201



Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

+ + Contractor Name:

**Denotes required field*

+ + Denotes field that is required if you were employed by a City Contractor.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Date From: Date To: Amount:

Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
Total:			0.00

Additional Claimed Damages

Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREED
Specify:	PUNITIVES CALCULATED BASED ON 3 X GROSS SALARY
Specify:	ATTORNEY FEES
Specify:	

Total:

****Total
Claimed
Amount:**

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

**Denotes field that is required.*

***Total Claimed Amount will be automatically calculated after all required fields are entered.*

New York City Comptroller
Brad LanderOffice of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

City Employment Claim Form

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I am filing: ☐ On behalf of myself.☐ On behalf of someone else. If on someone else's behalf, please provide the following information:

Last Name:

First Name:

Relationship to
the claimant:**Claimant Information**

*Last Name:

OREILLY

*First Name:

CHRISTINE

*Address:

Address 2:

*City:

*State:

*Zip Code:

*Country:

Date of Birth:

Soc. Sec #:

*Phone:

*Email Address:

*Retype Email:

Occupation:

TEACHER

Current City
Employee?

Yes



No



NA

Current Agency:

DEPT. OF EDUCATION

Gender:



Male



Female



Other

☒ Attorney is filing.**Attorney Information (if represented by attorney)**

+Firm or Last Name:

WOMEN OF COLOR 4 EQUAL JUSTICE

+Firm or First Name:

JO SAINT-GEORGE, ESQ.

+Address:

MAILING - 350 E. DIAMOND AVE.

Address 2:

UNIT 4077

+City:

GIATHERSBURG

+State:

MARYLAND

+Zip Code:

20877

Tax Id:

261289930

+Phone:

(602) 326-8663

+Email Address:

JO@WOC4EQUALJUSTICE.ORG

+Retype Email:

JO@WOC4EQUALJUSTICE.ORG

The time and place where the claim arose

*Incident Date from:

09/09/2021

Format: MM/DD/YYYY

*Incident Date to:

05/11/2022

Format: MM/DD/YYYY

*Incident Location:

ONGOING RELIGIOUS & DISABILITY
HARASSMENT & DISTRESS

Address:

60-02 60TH LANE

Address 2:

City:

MASPETH

State:

NEW YORK

Borough:

MANHATTAN (NEW YORK)

* Denotes required fields. Either a claimant or attorney email address is required.

+ Denotes field that is required if Attorney is filing.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

***Nature of Claim/Description of Claim**

THE WOMEN OF COLOR FOR EQUAL JUSTICE ARE REPRESENTING MULTIPLE CITY WORKERS AND IS SEEKING CLASS CERTIFICATION OF WHICH THIS EMPLOYEE HAS BEEN NAME AS PART OF THE PROPOSED CLASS. A LAWSUIT HAS BEEN FILED TO PRESERVE STATUTES OF LIMITATIONS. SEE DETAILS OF BELOW CLAIMS IN EXHIBIT A IN THE BELOW LINK - [HTTP://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM%20WITH-EXHIBITS-FINAL-V2.PDF](http://WWW.WOC4EQUALJUSTICE.ORG/LEGAL//NOTICE%20OF%20CLAIM%20WITH-EXHIBITS-FINAL-V2.PDF) - CLAIMS:

#1. OSHA PRE-EMPTION OF NEW YORK CITY DEPARTMENT OF HEALTH ORDERS - THE CITY THROUGH THE DEPARTMENT OF HEALTH LACKED AUTHORITY TO ISSUE THE COVID-19 VACCINE ORDERS FROM AUGUST 2021 TO DECEMBER 2021 THAT ONLY APPLIED TO CITY EMPLOYEES. ONLY OSHA HAS AUTHORITY TO CREATE AND IMPLEMENT WORKPLACE SAFETY STANDARDS. THE ORDERS WERE NOT FOR THE GENERAL GOO, CITY FAILED TO TRAIN EMPLOYEES REGARDING ALL OSHA RISK MITIGATION CONTROLS FOR WORKPLACE SAFETY AGAINST COVID-19 - SPECIFICALLY THE RIGHT TO "REMOTE WORK" AND SAFETY EQUIPMENT - SPECIFICALLY RESPIRATORS AND POWERED AIR PURIFYING RESPIRATORS (PAPR) -

#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

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If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

*Agency: DEPT. OF EDUCATION
Address: 65 COURT ST.
Address 2: #102
City: BROOKLYN
State: NEW YORK
Zip Code: 11201

Work days lost: 210

Amount Earned Weekly:

Amount Earned Yearly:

Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

+ + Contractor Name:

**Denotes required field*

+ + Denotes field that is required if you were employed by a City Contractor.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Date From: Date To: Amount:

Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
Total:			0.00

Additional Claimed Damages

Amount:

Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY	
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREEDOM	
Specify:	PUNITIVES CALCULATED BASED ON 3 X GROSS SALARY	
Specify:	ATTORNEY FEES	
Specify:		
Total:		

****Total
Claimed
Amount:**

--	--

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

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Brad LanderOffice of the New York City Comptroller
1 Centre Street
New York, NY 10007
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City Employment Claim Form

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I am filing: ☐ On behalf of myself.☐ On behalf of someone else. If on someone else's behalf, please provide the following information:

Last Name:

First Name:

Relationship to
the claimant:**Claimant Information**

*Last Name:

CHANDLER

*First Name:

CASSANDRA

*Address:

Address 2:

*City:

*State:

*Zip Code:

*Country:

Date of Birth:

Soc. Sec #:

*Phone:

*Email Address:

*Retype Email:

Occupation:

Current City
Employee?

Yes



No



NA

Current Agency: DEPT. OF EDUCATION

Gender:



Male



Female



Other

☒ Attorney is filing.**Attorney Information (if represented by attorney)**

+Firm or Last Name:

WOMEN OF COLOR 4 EQUAL JUSTICE

+Firm or First Name:

JO SAINT-GEORGE, ESQ.

+Address:

MAILING - 350 E. DIAMOND AVE.

Address 2:

UNIT 4077

+City:

GIATHERSBURG

+State:

MARYLAND

+Zip Code:

20877

Tax Id:

261289930

+Phone:

(602) 326-8663

+Email Address:

JO@WOC4EQUALJUSTICE.ORG

+Retype Email:

JO@WOC4EQUALJUSTICE.ORG

The time and place where the claim arose

*Incident Date from:

09/09/2021

Format: MM/DD/YYYY

*Incident Date to:

05/11/2022

Format: MM/DD/YYYY

*Incident Location:

ONGOING RELIGIOUS & DISABILITY
HARASSMENT & DISTRESS

Address:

150 WILLIAM STREET

Address 2:

City:

NEW YORK

State:

NEW YORK

Borough:

MANHATTAN (NEW YORK)

* Denotes required fields. Either a claimant or attorney email address is required.

+ Denotes field that is required if Attorney is filing.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

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If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

*Agency:	ADMINISTRATION FOR CHILDREN'S SE
Address:	66 JOHN STREET
Address 2:	#400
City:	NEW YORK
State:	NEW YORK
Zip Code:	10038

Work days lost: 210

Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

+ + Contractor Name:

**Denotes required field*

+ + Denotes field that is required if you were employed by a City Contractor.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Date From: Date To: Amount:

Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
Total:			0.00

Additional Claimed Damages

Amount:

Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY	2	
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREEDOM	4	
Specify:	PUNITIVES CALCULATED BASED ON 3 X GROSS SALARY	3	
Specify:	ATTORNEY FEES	5	
Specify:			
Total:		6	

****Total
Claimed
Amount:**

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

*Denotes field that is required.

**Total Claimed Amount will be automatically calculated after all required fields are entered.

New York City Comptroller
Brad LanderOffice of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

City Employment Claim Form

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I am filing: ☐ On behalf of myself.☐ On behalf of someone else. If on someone else's behalf, please provide the following information:

Last Name: NOTE: MR. DELLO IOIO HAS FILED A NOTICE
First Name: THIS IS TO CONFIRM THAT
Relationship to the claimant: WE REPRESENT HIM NOW.

Claimant Information

*Last Name: RIDULFO
*First Name: CHARISSE
*Address:
Address 2:
*City:
*State:
*Zip Code:
*Country:
Date of Birth:
Soc. Sec #:
*Phone:
*Email Address:
*Retype Email:
Occupation:
Current City Employee? ☒ Yes ☐ No ☐ NA
Current Agency: DEPT. OF EDUCATION

Gender: ☐ Male ☒ Female ☐ Other☒ Attorney is filing.

Attorney Information (if represented by attorney)

+Firm or Last Name: WOMEN OF COLOR 4 EQUAL JUSTICE
+Firm or First Name: JO SAINT-GEORGE, ESQ.
+Address: MAILING - 350 E. DIAMOND AVE.
Address 2: UNIT 4077
+City: GIATHERSBURG
+State: MARYLAND
+Zip Code: 20877
Tax Id: 261289930
+Phone: (602) 326-8663
+Email Address: JO@WOC4EQUALJUSTICE.ORG
+Retype Email: JO@WOC4EQUALJUSTICE.ORG

The time and place where the claim arose

*Incident Date from: 09/09/2021 Format: MM/DD/YYYY
*Incident Date to: 05/11/2022 Format: MM/DD/YYYY
*Incident Location: ONGOING RELIGIOUS & DISABILITY HARASSMENT & DISTRESS
Address: 3450 TREMONT AVENUE
Address 2:
City: BRONX
State: NEW YORK
Borough: BRONX

* Denotes required fields. Either a claimant or attorney email address is required.

+ Denotes field that is required if Attorney is filing.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

***Nature of Claim/Description of Claim**

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If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

*Agency: DEPT. OF EDUCATION
Address: 65 COURT ST.
Address 2: #102
City: BROOKLYN
State: NEW YORK
Zip Code: 11201

Work days lost: 210

Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

+ + Contractor Name:

**Denotes required field*

+ + Denotes field that is required if you were employed by a City Contractor.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Date From: Date To: Amount:

Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
Total:			0.00

Additional Claimed Damages

Amount:

Specify:	MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY	
Specify:	PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREEDOM	
Specify:	PUNITIVES CALCULATED BASED ON [REDACTED]	
Specify:	ATTORNEY FEES	
Specify:		
Total:		

****Total
Claimed
Amount:**

[REDACTED]	
------------	--

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I am filing: ☐ On behalf of myself.

☐ On behalf of someone else. If on someone else's behalf, please provide the following information:

Last Name:

First Name:

Relationship to
the claimant:

Claimant Information

*Last Name: BAKER-PACIUS

*First Name:

*Address:

Address 2:

*City:

*State:

*Zip Code:

*Country:

Date of Birth:

Soc. Sec #:

*Phone:

*Email Address:

*Retype Email:

Occupation:

Current City
Employee? ☒ Yes ☐ No ☐ NA

Current Agency: DEPT. OF EDUCATION

Gender: ☐ Male ☒ Female ☐ Other

☒ Attorney is filing.

Attorney Information (if represented by attorney)

+Firm or Last Name:

+Firm or First Name:

+Address:

Address 2:

+City:

+State:

+Zip Code:

Tax Id:

+Phone:

+Email Address:

+Retype Email:

WOMEN OF COLOR 4 EQUAL JUSTICE

JO SAINT-GEORGE, ESQ.

MAILING - 350 E. DIAMOND AVE.

UNIT 4077

GIATHERSBURG

MARYLAND

20877

261289930

(602) 326-8663

JO@WOC4EQUALJUSTICE.ORG

JO@WOC4EQUALJUSTICE.ORG

The time and place where the claim arose

*Incident Date from:

09/09/2021

Format: MM/DD/YYYY

*Incident Date to:

05/11/2022

Format: MM/DD/YYYY

*Incident Location:

ONGOING RELIGIOUS & DISABILITY
HARASSMENT & DISTRESS

Address:

370 WEST 120TH ST.

Address 2:

City:

NEW YORK

State:

NEW YORK

Borough:

MANHATTAN (NEW YORK)

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#1. OSHA PRE-EMPTION OF NEW YORK CITY DEPARTMENT OF HEALTH ORDERS - THE CITY THROUGH THE DEPARTMENT OF HEALTH LACKED AUTHORITY TO ISSUE THE COVID-19 VACCINE ORDERS FROM AUGUST 2021 TO DECEMBER 2021 THAT ONLY APPLIED TO CITY EMPLOYEES. ONLY OSHA HAS AUTHORITY TO CREATE AND IMPLEMENT WORKPLACE SAFETY STANDARDS. THE ORDERS WERE NOT FOR THE GENERAL GOO, CITY FAILED TO TRAIN EMPLOYEES REGARDING ALL OSHA RISK MITIGATION CONTROLS FOR WORKPLACE SAFETY AGAINST COVID-19 - SPECIFICALLY THE RIGHT TO "REMOTE WORK" AND SAFETY EQUIPMENT - SPECIFICALLY RESPIRATORS AND POWERED AIR PURIFYING RESPIRATORS (PAPR) -

#2 - BECAUSE THE CITY LACKED AUTHORITY TO CREATE, IMPLEMENT, ENFORCE AND DISCIPLINE BASED ON UNAUTHORIZED ORDERS, THE CITY VIOLATED THE CLASSES FIRST AMENDMENT RIGHTS TO FREE EXERCISE AND VIOLATED THE ESTABLISHMENT CLAUSE FOR FAILING TO PROMOTE AND ALLOW EMPLOYEES TO CHOOSE ALTERNATIVE RELIGIOUS MEDICAL TREATMENTS TO DEAL WITH COVID-19 IN THEIR BODIES.

#3 THE CITY ENGAGED IN DISCRIMINATORY HARASSMENT AND COERCION IN VIOLATION OF: TITLE VII, THE ADA (THE EMPLOYEES IN THE PROTECTED CLASS OF THOSE WITH A "PERCEIVED DISABILITY" DUE TO THEIR "UNVACCINATED STATUS" OR "VACCINE DEFICIENCY") AND IN VIOLATION OF THE NEW YORK CITY HUMAN RIGHTS ACT FOR THE SAME REASONS ABOVE. #4 WRONGFUL DISCIPLINE - THE CITY WRONGLY PLACED EMPLOYEES ON INVOLUNTARY INDETERMANAT LEAVE WITHOUT PAY BUT CLAIMED TO TERMINATE THEM IN VIOLATION OF CIVIL SERVICE LAWS A. EDUCATION LAW §3020 FOR ALL TENURED TEACHERS IN THE DEPARTMENT OF EDUCATION;

If you need additional room, attach your description as an additional document.

What agency/employer are you making this claim against?

*Agency: DEPT. OF EDUCATION
Address: 65 COURT STREET
Address 2:
City: BROOKLYN
State: NEW YORK
Zip Code: 11201

Work days lost:

210

Amount Earned Weekly:

Amount Earned Yearly:

Were you employed by a City Contractor at the time of claimed occurrence?

☐ Yes☐ No

++Contractor Name:

*Denotes required field

++Denotes field that is required if you were employed by a City Contractor.



New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
FormVersion: NYC-COMPT-BLA-LE-C4

Salary/Benefit Claimed Damages

Date From: Date To: Amount:

Overtime:

Compensatory time:

Differential:

Annual Leave/Vacation:

Sick Leave:

Salary:

Total:		0.00

Additional Claimed Damages

Amount:

Specify:

MENTAL DISTRESS DAMAGES FOR HARASSMENT + COERCION = 2X SALARY

Specify:

PUNITIVE DAMAGES FOR RECKLESS DISREGARD FOR MY MEDICAL FREEDOM

Specify:

PUNITIVES CALCULATED BASED ON 3 X GROSS SALARY

Specify:

ATTORNEY FEES

Specify:

Total:

****Total
Claimed
Amount:**

--	--

I certify that all information contained in this notice is true, and correct to the best of my knowledge, and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties, and civil liabilities.

*Denotes field that is required.

**Total Claimed Amount will be automatically calculated after all required fields are entered.

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101216

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:BRYAN

Claimant First Name:AMOURA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101211

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:VELEZ

Claimant First Name:ANGELA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101279

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:MOODY

Claimant First Name:AURA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101218

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:USTARES

Claimant First Name:AYSE

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101236

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:REID

Claimant First Name:BRUCE

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101199

You uploaded:

Claim Form: 1

Supporting Documents:0

5/11/2022 12:00 AM

Claimant Last Name:GRANT

Claimant First Name:CARLA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101231

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:CHANDLER

Claimant First Name:CASSANDRA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101225

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:RIDULFO

Claimant First Name:CHARISSE

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101270

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:OREILLY

Claimant First Name:CHRISTINE

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101230

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:BOYCE

Claimant First Name:CURTIS

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101281

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:BAKER-PACIUS

Claimant First Name:DIANNE

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101282

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:WEBER

Claimant First Name:EDWARD

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101284

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:LOIACONO

Claimant First Name:ELIZABETH

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101269

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:ZAPATA

Claimant First Name:EVELYN

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101237

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:TROTMAN

Claimant First Name:FRANKIE

eCLAIM Receipt

You have successfully filed your claim.

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Your Receipt Number is the following:

202200101247

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:HUNTER

Claimant First Name:JEFFEREY B.

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101275

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:CSEPKU

Claimant First Name:JESSICA

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101195

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:COMBS

Claimant First Name:JESUS

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101234

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:RULLO

Claimant First Name:JOSEPH

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101208

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:HARDING

Claimant First Name:JULIA

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101205

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:CAMPELL

Claimant First Name:KAREEM

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101252

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:FIGARO

Claimant First Name:MARIA

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101271

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:ROMERO

Claimant First Name:MARITZA

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101227

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:MAYNE

Claimant First Name:MARK

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101203

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:HEMMINGS-HARRINGTON

Claimant First Name:MICHELLE

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101277

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:HOGAN

Claimant First Name:NATALYA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101250

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:ODOM

Claimant First Name:RASHEEN

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101221

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:DELLO IOIO

Claimant First Name:REMO

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101276

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:MUSTACCHIA

Claimant First Name:ROSEANNA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101215

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:BROWNE

Claimant First Name:SANCHA

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101207

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:COOMBS - MORENO

Claimant First Name:SARA

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101240

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:MILAN

Claimant First Name:SEAN

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101273

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:HERNANDEZ

Claimant First Name:SONIA

eCLAIM Receipt

You have successfully filed your claim.

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Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101268

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:DEEGAN

Claimant First Name:SUZANNE

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101197

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:TRACY-ANN

Claimant First Name:FRANCIS MARTIN

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101274

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:SMITH

Claimant First Name:YULANDA

eCLAIM Receipt

You have successfully filed your claim.

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If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

202200101219

You uploaded:

Claim Form: 1

Supporting Documents:1

5/11/2022 12:00 AM

Claimant Last Name:WOUADJOU

Claimant First Name:ZENA